


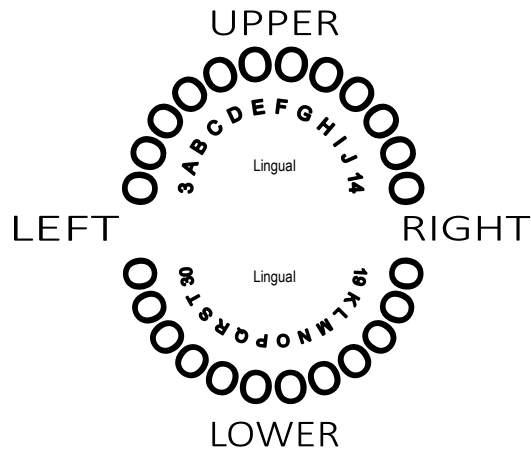


West River Head Start DENTAL EXAM / ORAL HEALTH FORM

Patient Information		
Child's Name:	Child's DOB:	Date Exam / Screening Completed:

Current Oral Health Status

ORAL CONDITION	
Missing	
Decayed	
Filled	



Number of times per day child brushes teeth: _____

Gum Condition: Normal Swollen Bleeds Easily Infected

Are there treatment needs? Yes, urgent Yes, not urgent No treatment needed

Oral Health Care Services Delivered During Visit		
Diagnostic / Preventive Services X-rays: Yes <input type="checkbox"/> No <input type="checkbox"/> Risk assessment: Yes <input type="checkbox"/> No <input type="checkbox"/> Cleaning: Yes <input type="checkbox"/> No <input type="checkbox"/> Fluoride varnish: Yes <input type="checkbox"/> No <input type="checkbox"/> Dental sealants: Yes <input type="checkbox"/> No <input type="checkbox"/>	Counseling / Anticipatory Guidance Yes <input type="checkbox"/> No <input type="checkbox"/> Referral to Specialty Care Yes <input type="checkbox"/> No <input type="checkbox"/> _____ <i>(Please specify specialist)</i>	Restorative / Emergency Care Fillings: Yes <input type="checkbox"/> No <input type="checkbox"/> Crowns: Yes <input type="checkbox"/> No <input type="checkbox"/> Extractions: Yes <input type="checkbox"/> No <input type="checkbox"/> Emergency care: Yes <input type="checkbox"/> No <input type="checkbox"/> Other: _____ <i>(Please specify)</i>

Future Oral Health Care Services	
All treatment completed: Yes <input type="checkbox"/> No <input type="checkbox"/>	Next recall date: _____/_____/_____ (month/year)
More appointments needed for treatment? Yes <input type="checkbox"/> No <input type="checkbox"/>	
If yes: Approximate number of appointments needed: _____	Next appointment: Date: _____ Time: _____
Additional Information for parent, head start staff, and medical providers:	

Oral Health Provider's Contact Information and Signature		
Provider Name (printed)	Phone Number	Fax Number
Provider Signature	Date	Address

Please return form by fax to (701) 663-9643 or mail to:			
West River Head Start 1004 7th Street SW Mandan, ND 58554 Tel (701) 663-9507	West River Head Start PO Box 197 Carson, ND 58529 Tel (701) 622-3505	West River Head Start PO Box 487 Hazen, ND 58545 Tel (701) 748-3736	West River Head Start PO Box 197 New Salem, ND 58563 Tel (701) 843-8061